10 Special Topics

Introduction

It is inevitable that the subject of this chapter must differ from that of Vol.1 (i. e., the relationship between theory and practice). The numerous examples we have given provide sufficient clarification of this relationship. Moreover, it is impossible for a clinical textbook to satisfy the requirements that the theory of science today poses to Freud's inseparable bond hypothesis about research and therapy.

In this chapter we will instead familiarize our readers with specific problems that are of great practical significance. The issue of consultation, covered in Sect. 10.1, is just one example. The subject of religiosity also deserves our special attention, both for therapeutic and interdisciplinary reasons (Sect. 10.3). Furthermore, as shown by the example of a "good hour," the participation of scientists from other fields in the study of the psychoanalytic dialogue leads us back to the hypothesis of an inseparable bond (Sect. 10.2).

10.1 Consultation

We distinguish, as did Szecsödy (1981), between consultation, which is a meeting in which colleagues meet as equals and one advises the other, as has always been the case when difficult diagnostic and therapeutic problems are confronted, and supervision, which is a learning situation within the framework of training. The process of supervison includes both overseeing and evaluating; participation is obligatory, in contrast to a consultation, which is voluntary. Three persons are involved in a consultation, namely the patient, the therapist, and the consultant. In supervision there is also a fourth element, namely an institution, i. e., the training institute whose standards are set and watched over by national and international bodies.

Because of his distance to the dyadic interaction between patient and therapist, the perspective of an outside analyst differs and in some regards is wider than that of the analyst providing the treatment. Since he is not entangled in the transference and countertransference processes, he is in a good position to make the therapist aware of the consequences and side effects of his feelings and thoughts.

A study of the complex issues of supervision and consultation that attempts to provide more precise answers to important questions than has been possible until now must utilize an approach that is both comprehensive and multifaceted. In this section we report on an excerpt from a study based on the following design. Ten successive sessions were transcribed. Between every session the therapist consulted a colleague experienced in supervision. Prior to the consultation the colleague studied the transcripts in detail and dictated his comments, which are included in the text and marked as such.

The colleague's comments demonstrate that, while the analyst bases his understanding and interventions on a strategy, the consultant himself relies on his own conception to view the interaction. In order to make the consultant's comments and suggestions more comprehensible, we will first cite several important passages indicating Szecsödy's understanding of supervision.

The supervisory situation will provide conditions in which learning can develop. To achieve such conditions is not easy and can be complicated by trainee as well as by supervisor. Parallel to the wish to learn and change, there is the fear from the unknown and a tendency to stay with the accustomed and to remian untouched by change.

There are many ambiguities in the supervisory situation:

- The trainee is a beginner, without much knowledge and/or skill. He has to be open and honest about this in his supervision as well as with himself. On the other hand he is expected to be an optimally good therapist for his patient.

Another ambiguity stems from the fact that in the therapeutic relationship he is a "real person" with his professional and personal characteristics as well as a transference "object" for the patient. As a transference object he is placed in different and for him often foreign roles.

- Within the supervisory interaction, the therapist is reconstructing the process he is part of. He is also a trainee, who has to expose himself to the supervisor who aids, teaches and judges him.
- These positions for trainee and supervisor stimulate different emotions and reactions, both rational and irrational, conscious and unconscious. There is "a crowd present" in the supervisory room: a mentor, teacher, evaluator, judge, supervisor, future colleague, a staff member who is dependent on the candidate's acknowledgement and successful development, as well as the candidate himself who has to accept and carry a number of different roles.

The supervisor has to be prepared for and be aware of all these ambiguities and the problems these arouse. He has to work with them in different ways. The complex interaction between trainee and supervisor is influenced by many factors: the personalities of the patient, the trainee, the superviosr as well as how they are affected by the organisation they work in. (Szecsödy 1990, p. 12)

For change and growth to be facilitated, it is essential that the analyst create the necessary *space* . The figurative use of the concept of space refers back to qualities that Winnicott described with the image of an "intermediate area."

Since the goal is maximal frankness, it is logical that special attention in supervision and consultation is directed at the points at which the therapist impedes the development, either because of insufficient knowledge about the patient's specific disturbance or for emotional reasons, i. e., because of a situative or habitual countertransference. Szecsödy adopted the terms "dumbness" and "numbness" from Ekstein and Wallerstein (1972) to describe these obstructions.

The following presentation of the 114th session of Arthur Y's treatment has been enriched by the addition of information from other transcripts and supplemented with the consultant's comments.

Arthur Y began the session by telling me about an experience that was typical for him. He had recently discovered that he could get more space for himself by enlarging his study. In the process, he installed wood paneling. While doing this work he felt very insecure and thought to himself, "If I don't do a good job, I'll be faced by chaos." He used a fairly hard wood, and with some fantasy he imagined he could see the letter W in the grain. This gave him the idea, "Boy, turned around, W looks like M, M for murder, like in the movie M from the 1930s in which a man called himself M after he had committed a murder."

P: Typical! I was really terribly mad at myself. I managed to do everything right and then such nonsense, such an insane idea. Instead of being happy, I have to spend all my time thinking about whether I should replace all the panels. I just recalled that you're not going to be here next week. And I'm overcome by the feeling of being at somebody's mercy, the feeling of being left alone, because I can't talk about it with anyone else; they would just think I'm crazy.

Comment. The patient said that he had created more space for himself and that he then had encountered a danger. It is impossible for him to combine ties and independence. When he is mad at the analyst-father, for leaving him, his anger takes on murderous force. The analyst interpreted the symptom in connection with the patient's frequent changes in mood. Although the patient's happiness, enthusiasm, and pride at his good work increased, so did his critical self-evaluation and self-condemnation.

The analyst did not pick up the patient's remark about his feeling of being left alone, as was verified in the consultation. Instead of this, he focused on pride.

P: If it weren't the M, then it would be something else. It just completely ruins my satisfaction at having finished the work. I feel so much spite, am so mad! The

panels stay where they are. I wouldn't think about doing all that work over again! I'm mad at this constant latent threat, which I've already experienced a thousand or ten thousand times.

A: This seems to be something new, what you've just thought about, I mean the increase in your rage.

P: Against whatever it is that keeps me from settling down.

A: Anger at what's confronting you.

P: That seems new to you? Haven't I ever talked about it before? Rage isn't anything new to me. I could smash the wood paneling to pieces.

A:That wasn't clear to me before.

P: For a second I think, "I'll take the panels down!" Then spite; "I wouldn't think of it!" I can't move everything that's ever made me feel afraid out of my way; I'd be busy forever trying to get things right.

Comment. Here the patient clearly revealed how he struggled against his previous maladaption. He wanted to retain his autonomy. He did not want to simply avoid things, he wanted to put his aggressive power to constructive use.

A: Yes, it's a real duel! A duel against the brutal superiority of this world, against the power of the oppressive object that's attacking you, that's directing your anger at being suppressed.

Comment. Although the analyst referred to the central issue by mentioning the internalized conflict (which the patient repeatedly had no difficulty in externalizing), in my opinion this was not the right time to make a historical generalization. The analyst should have worked through the rage in the relationship to himself.

P: Yesterday, despite all the chaos in my room, we were invited out. In the evening my son played the organ solo in the chapel. For 18 months now it's been a matter of routine for us to go with him and not to let him play alone. And for me it's an opportunity to hear how he's progressing.

A: And there's pride in sitting in the hall and being there when your son fills the space with music.

Comment. Another allusion to the analyst, who left and did not accompany the patient's progress. It would be important to know why the analyst put so much emphasis on pride. Is he proud of the patient or of himself? Is it a reaction to how the patient filled the space, e. g., found more room for himself and even wanted to fill the therapist's office?

P: This time it was impossible to go with him. We were invited out . . . . The point now in the back and forth of the feelings about tearing the paneling down or not is not really the work that's involved; the point is whether I let myself be conquered by my anxiety. Some time I'm bound to completely get over the problem with the help of analysis.

A: That's the one side, whether you let yourself be conquered or whether you're the one who's stronger. The other side, which may seem construed to you, is that your enemy is the benign one [a sadistic teacher at the boarding school] or a panel is the devil. So when you tear it down and smash it to pieces, then you're the winner. To make another big leap, it's a duel you're fighting with the panel, whether analysis helps or not. That you're mad at me, and when you leave today, mad that you haven't overcome it again and want to use the panel to beat me to pieces.

Comment. The patient spoke about his chances for coping with his enemies, such as anxiety and dependence. He was struggled for his autonomy, although he wanted to maintain his relationships. There is thus a conflict between his dependence and independence that is filled with spite and sadistic

aggressiveness. The analyst took himself to be the object of rage. Why? It might be better to illuminate the patient's lack of autonomy by referring to the analyst's relative freedom (child-adult). The analyst can decide without any anxiety: He can go away and leave the patient behind with his anxieties. The question remains to be answered as to why the analyst did not pick up the patient's remark about the forthcoming separation.

P: I feel as if I were sitting in a trap, in a real dilemma, and time is just running out. If it weren't the paneling it would be something else. I don't really understand, suddenly feel anxiety, because I see this figure, somehow as if it were simply time once again to have a real dose of anxiety.

A: Or it's time to be mad, to feel the immense pleasure of being proud. Like the SS officer. [A reference to an event described in Sect. 8.3.] And then this pride contains something that is almost evil or cruel, an infinite arrogance.

P: Yes, I don't know. It seems to me that what you're saying today is so abstract, and that hinders me.

A: Yes, it is abstract. I've already hinted at one side of the matter, namely that when you are successful and are really happy, satisfied, and proud, that then the thought comes to you, "Well who is unsuccessful?" And it's followed by the thought that disturbs you and that you want to get rid of: that I'm the one who's helping you . . . .

P: Yes, are you finished already?

A: Yes, I'm finished.

P: It seemed to me [laughing] that you stopped in the middle of the sentence.

A: Hum.

P: Yes, for me it was - when I'm successful at doing something practical, it's bound up with astonishment. For a long time I thought I couldn't do it. And when I see it, I'm proud, but not very long . . . . And I can't remember anything of what you just said.

A: That the thought proves that I can't do anything.

P: [Laughs] And that is supposed to fill me with pride? I don't understand. I hung myself onto you, so to speak. If I compare you to a branch that I'm sitting on, well if it breaks, then I'll fall down. And that's supposed to fill me with pride?

A: Yes, that I can't finish anything.

P: But why is that supposed to make me feel happy? I can't understand it at all. What do I have from it?

A: Yes, like I said, it seems a bit construed to me, too.

P: I'm amazed that you can even have such an idea. That could only be true if I considered you a rival, that would be the only time I'ld be pleased to discover that you can't do anything. I come here to get help, the same as anybody who goes to a doctor. Nobody can be happy if he discovers that the person he has put his confidence in is incapable, a complete loser. I have the feeling that today we've got a knot somewhere.

Comment. The patient made an offer to the analyst that they determine how far the dialogue has progressed.

A: Yes, there's a knot, caused by my thoughts . . . . I didn't assume that your pleasure would come from denying my value as a craftsman. It's important to you that I'm good at my craft. That's not what I mean, but that there's an antagonism, together with an intensive struggle and rage, when you aren't begrudged the pleasure of your own success. And I tried to get involved in the struggle between you and the panels.

P: [Laughs a little] That sounds as if it's on the verge of insanity, the struggle between me and the panels. Maybe I'm just especially sensitive today . . . . Yes, it's awfully complicated, emotional life is. Yes, enjoy life, don't look for the thorns and find them. That's how you could describe my life.
A: Yes, when the thorns prick you, you feel pain, then get mad, and would like to tear them out and throw them away.

Comment. Most painful for the patient is: "It hurts to have to accept help. Angry and omnipotent, I want to destroy whoever leaves me and makes me painfully aware of my dependence." The analyst could work this out better, together with the patient. A good topic for the coming consultation.

The Consultation

We now give a summary description of the consultation, at the beginning of which the consultant said they should clarify how the analyst could best work with the patient's conflict (his struggle between autonomy and dependence). The analyst emphasized that he thought the session had been bad because he had offered too many intellectual constructions, with the intention of giving "the senseless symtom a meaning." He was dissatisfied because he had not managed to demonstrate that the patient wanted to deny the analyst success in their struggle. At this point the consultant reminded the analyst of a Freud quotation (1905e, p. 120) that he must have been aware of: "For how could the patient take a more effective revenge than by demonstrating upon her own person the helplessness and incapacity of the physician?" The two of them then reconstructed the course of events in this session and agreed that the "knot" - as the patient had referred to it - was the task for this consultation.

C: First I would like to hear, when you think back, whether are you dissatisfied? You made a knot - what can we do with it? Would you give your thoughts free reign to find out what you wanted to do?
A: Right now I think of - it goes well with a thought that I also had in the session - that one aspect of his overall desire and satisfaction is that he destroys what he has just made. Since the object becomes an enemy that he conquers, one part of this is that he first creates the object, but only to then ruin it.
C: Symbolically.
A: Yes, if I'm the one who suggests to him that he should let his anxiety work a little and try to delay his compulsive acts, then I'm the one who limits his pleasure.
C: The pleasure to destroy something.
A: Yes, and when he comes the next time, after he really felt good, he will have destroyed something again, and I obviously wanted to do something in order to ensure that the panels stay up and that he wouldn't destroy them. Today I wanted to give him some desire for satisfaction.

After the consultant asked the analyst to let his thoughts have free reign - which is not necessarily the same as free association, and more likely means thinking out loud in a relaxed atmosphere - the analyst discovered his part in the duel. By having done something, he also obstructed the patient. Instead of first letting things take their turn, he was interested in keeping the patient from destroying the panels. The analyst also assumed that he himself had a very strong interest in the success of the treatment. It was clearly apparent that the analyst had left his neutral position because of his desire to keep the patient from destroying what he had created.

In another step the consultant referred to the topic of being left alone, which he had noted while reading the protocol. It was obvious that the analyst simply had not heard this topic despite the patient's clear references to it, such as "left," "at someone's mercy," and "lonely."

The confrontation with the material revived his memory but not the affective evidence that this might have been a dynamically relevant subject in the session.

A: I was simply on my own trip in the session. And after I had once gotten on it, I lost the flexibility to leave it again.
C: You started from the theory that he builds up his object over and over, only to destroy it. I see the following dynamic: The patient talked a lot about autonomy. You did not manage to present the subject of competition and success in a convincing manner; it appeared construed. Nonetheless your topic arose in the interaction and it led to an interaction. Instead of leading to cooperation and shared happiness at the success, it led to a duel. You didn't want to permit him to destroy what the two of you had built. But the patient felt left alone, as he illustrated with reference to his son, whom he did not want to let play by himself and yet had to leave.
A: Now I know why I didn't listen better: I was following another line of thought, not the one that he didn't want to let his son play by himself, but the one that he was so proud that he had to be there. In another sense, it also means that he cannot leave his son alone because he then loses his chance to participate in and identify with his son's success.

These comments confirmed the consultant's understanding that the analyst had reached this line of thought and stuck to it because he was just as identified with being successful in his therapeutic work as the patient was with his son. The result was the struggle between son and father and between patient and analyst. The consultant attempted, in the following excerpt, to demonstrate the potential of this view.

C: The idea of pride has both a positive and a negative aspect in a typical father-son relationship. They can be proud together, but they can also be rivals and react in the manner "I want to do it alone, just for myself. And I won't do it there because you always spoil my pleasure of having done it by myself."
A: Yes, there was a place where the patient said, "If I were like that, took pleasure in disparaging you, yes then I would be insane."
C: Yes, and then you said, "You have to use me as a good therapist." But if the patient experiences your success as exorbitant, then you will become involved in the struggle. I believe, to come to the heart of the matter, that we are working in different ways with the same image. I focus on the father-son dynamic: he killed his father and has to invent another one over and over in order to enable both of them to win if he feels well. But his desire for autonomy was filled with disappointment and anger when he was left alone.
A: The interesting aspect of our talk is the further development of my theory that although he had adopted our commandment, he felt anger and the desire to violate the prohibition. Now I'm curious whether he will tear down the panels or not. I hope I can be open for each outcome.

The course of this session made it clear to the consultant that a duel first took place until the analyst also responded to the other point of view. As a consequence of his desire to keep the patient from doing something, in order to feel successful himself, the analyst left his neutral ground and entered into a duel with the patient.

10.2 Theoretical Remarks About a "Good Hour"

The session following the consultation described in the previous section, the 115th, went so well that it immediately reminded the analyst of the concept of the "good hour" (Kris 1956). Elsewhere we have already published a comparison of the bad 114th and the good 115th sessions (see Löw-Beer and Thomä 1988).

We would like to draw attention to a special aspect of the following presentation. It has turned out to be unusually productive for both psychoanalytic practice and research if transcripts of therapeutic dialogues are examined by independent third parties, i. e., scientists from other disciplines. This can, first, put empirical process research on a solid footing. Furthermore, philosophers, for example, can study psychoanalytic texts, and the discussion between the social sciences and psychoanalysis is given a contemporary and objective starting point. Our psychoanalytic thinking and actions have substantially benefited from interdisciplinary cooperation in working with transcripts. The interpretation of a philosopher that is given below is an instructive example.

Object of the examination was a "good" hour. In order to understand what this means, it is first necessary to clarify what constitutes a patient's positive changes in a session.

The concept of a good session must be discussed from at least two perspectives. The first is to clarify what constitutes good interaction and the accompanying experiencing in analysis, for example whether the patient's insights and the analyst's interpretations complement each other and whether the patient feels understood (Kris 1956; Peterfreund 1983). The second perspective, which is our special focus of interest, is the curative change that is mediated by the interaction with the analyst. We must also ask whether unsuccessful interaction with the analyst - e. g., feeling not understood - can result in curative changes if the lack of empathy becomes the object of the dialogue.

It is possible to attempt to synthesize the different points of view on these questions once the differences are clear. The danger of an unreflected synthesis can be found in the literature, specifically if attention is only directed at the development of the patient's capacities that make a good session possible. Meant are the capacities for psychic integration, self-observation, and controlled regression. The article by Kris mentioned above does not avoid this trap completely, just as Peterfreund's comments are not entirely free of emphasizing qualities in patients that make adjusted analysands of them. It remains dubious, namely, whether the capacities that make a good session of analysis possible are identical with those necessary in ordinary life.

Attempts have been made to provide both descriptive and causal groundings of what is good and bad in sessions and what elicits relevant changes in a patient. Causal groundings must be taken with some caution, inasmuch as they are hypotheses that must be tested in other cases. Characteristic of a bad session is, for example, that the analyst disregards the patient's knowledge about his symptoms and suggests alternative interpretations. In a good session, in contrast, the analyst extends the patient's dealings with his symptoms in a manner permitting the patient to integrate disparate elements of his life history and to develop an emotionally and intellectually adequate perspective toward his own biography. Presumably, both the analyst's style of communication and his interpretations are relevant to the patient's positive development. A particular manner of communication, which we also call "dramaturgic technique," might be a valuable type of therapeutic action.

The following comments are based on the analysis of Arthur Y, who had suffered from obsessive thoughts since his youth. The most conspicuous aspect of his symptoms was his obsessive thought that he had to murder his own children, which appeared worse to him than dying. These obsessive thoughts led in a typical manner to defensive actions: "You will only be prevented from killing your children if you do this and that." Thus for a while he feared a cruel God, who could force him to murder his children if he were not obedient. In the patient's words, "As if God . . . were an officer in the SS . . . who, if I didn't greet him in the perfect way, might punish me with death or perhaps something even worse . . . . I would kill one of my own children, which would be worse than death."

The 115th session was a breakthrough session. In it the patient underwent a positive change that was spectacular. He came to the session feeling anxious and resigned, with the

attitude of being a victim that was typical for him, and left it feeling liberated. Arthur Y found an almost poetic power of expression. His feeling of rage at having to bow to an evil power was previously limited to his symptoms; in the session his swaying between rage and powerlessness also came to be the decisive element in his relationships to persons of authority. His experiencing of this was extended from his symptoms into other situations in which it appeared appropriate. To use the analyst's words, "The patient has rediscovered his feelings." The analyst's hypothesis was that these were the conflicts to which the patient had reacted with pathogenic defense processes.

We summarize the session, concentrating on the aspects we believe facilitated the patient's development. We presume that the patient's insights into himself were not the cause of the change, but rather that the analyst's encouragement was vital in helping Arthur Y find emotionally appropriate reactions to situations of submission. The result was a particular form of insight, the patient acquiring an accurate understanding of his situation.

In the following scene the analyst acted like a director who prompted the patient to put himself into the roles that he recalled. He did this by extending dramaturgically the script, i. e., in this case the patient's recollections. The patient talked about a surgeon he had found unsympathetic and who had removed his tonsils under a local anesthetic. The patient had been afraid and constantly wanted to swallow; the doctor had barked at him to keep his mouth open.

A: Oh, there's so much blood.
P: Yes.
A: It makes you want to swollow all the time and makes you afraid of suffocating, as if you were up to your neck in water, or rather blood.

Consideration. I thought of the allusion to water because the patient had once been in a very dangerous situation and almost drowned.

A: The scalpel he used to cut you and to make you almost suffocate. That's how you experience it when the blood runs together back there in your throat. And if you spit blood in his face, then you have to fear that he'll get even angrier.
P: Yes, and to pick up this line of thought, how do you defend yourself in such a situation? An eye for an eye would be logical.
A: Yes, and there are the instruments, namely the scalpel or other sharp objects.
P: But you rule out such thoughts immediately.
A: They're also ruled out by the situation. The surgeon is just too powerful.
P: And then when you suppress it, so to speak, and suppress it over and over, then it just comes somewhere else - the scalpel. It even comes where - now I have an idea. If I were a 9-year-old boy and simply took the next object and shoved it through his face, then as a child I would expect him to finish me off.
A: If you take the scalpel he's using to cut you up.
P: So if I defend myself, then he'll finish me off, then it's over. Then it's over and I'm done for, just the same as what I'm still afraid of today.
A: Yes.
P: With the scalpel I would just end up the same, I'd be done for, finished, over.
A: Yes, and with the scalpel you're the powerful surgeon, SS officer, Hitler, etc., God the Almighty with the knife, and in the small children you yourself are a child; you're a victim.
P: Yes, yes.
A: But you don't mean your children, of course. You mean the immense power, but it's so terrible that nobody can point the scalpel at you, and this has implications for more distant, seemingly harmless things, such as you're not permitted to criticize the therapist, me.
P: I've understood you so far good, and you say "You don't mean your children . . . " but I mean Benignus, to use this to refer to everything vicious

[the synonym he used to refer to a sadistic teacher, whose true name had a similar contradictory quality].

A: Yes.

P: My opponent, my enemy. I don't want to lose sight of the image that my anxieties in reality aren't about my children but about an enemy that I don't dare defend myself against. And when I let it pass review, then I can clearly feel that I have the same feelings toward you when you talk about increasing your fee, for example.

Arthur Y was then overcome by feelings of revenge and powerlessness. Although he had just been submissive in his attitude that he was a victim, he suddenly began, in dramatic monologues, to settle old scores with his various oppressors: his father, who had not attempted to understand him, but instead had punished him after a boyish prank and then gone away to war - never to return - without even saying goodbye; the patient would most of all have liked to attack him with a weapon. He would have liked to have his way with his sadistic teacher. He was mad at his mother from cheating him out of his childhood. Finally he attacked me, the analyst, because I had forced him to confess. He compared this compulsion, grinning, with the image of a dog that you have to carry to the hunt, i. e., he felt forced to do something that he actually instinctively wanted to do. He accused me of having provoked feelings of revenge in him that he could not satisfy. He made this accusation part of an impressive image of a man who could not even release his excitement by masturbating because he did not have any hands.

P: Yes, and here come all of these figures and become alive, and I get terribly mad about all of these years - who should I pay it off to? There's nobody there [mumbling]. I had the following thought. What's the use of getting horny somewhere if I don't, well if I don't have a woman or even two hands to satisfy myself?

What makes this session a *good hour* ? What grounding is there for the intuition that it was a good session? What came of the breakthrough? In the following, we briefly discuss three important features of a good session.

An Improved Perspective About One's Own Past and Present

Prior to this breakthrough session, Arthur Y had been incapable of applying some values that were important to him to his own biography. He had held a view of his biography - rooted both in his intellect and, more importantly, in his experience - that was the opposite of his later ideal self-image. His later self-image conformed to the broad cultural consensus that both the patient and analyst accepted.

We understand a child who reacts to being mistreated by feeling intimidated and anxious, but when an adult goes through such oppressive situations we expect him to be indignant and mad at the persons who have treated him in such a manner. We believe that children should not be unnecessarily punished and not at all tormented, that we should let them have scope for playing, and that we should not force them to share our concerns. Arthur Y also shared these views and acted accordingly toward his own children. Yet for a long time he had been unable to grasp his own life history from this perspective. In the forefront was not only his rage and indignation at having been mistreated, but also the cries of the victim. As an adult he manifested this mentality of being the victim in an exaggerated form. Even the mere thought that a person higher in the social hierarchy might criticize him precipitated the panic that he might be ruined. In the role of the person being addressed, he was incapable of distinguishing between arbitrary demonstrations of power and legitimate claims to authority.

The impression that this session embodied a breakthrough was due in part to the fact that Arthur Y not only complained intellectually about having been denied his elementary rights as a child, but that he felt himself deprived of his rights, experienced this as an existential loss, and reacted to it by becoming enraged. His emotional reactions became more appropriate, toward the past as well as in the present toward his analyst, both from his own perspective and from that of a third party. In the preceding sessions the patient had reacted several times in an outspoken, even panicky way toward the analyst. These situations were characterized by the dissonance between the patient's immediate judgments and his rational ones. Although he grapsed that the analyst's increased fee was not intended to ruin him, and that it in fact would not do so, he emotionally experienced the demand as a threat to his existence. The accusations he directed at the analyst in the good session were, in contrast, not the result of panic. He accused the analyst of coercing him into making a confession. Since he realized that he also felt a need to communicate, he added an ironic element to his criticism by including the image of a dog that had to be carried to the hunt, reaching a differentiated description of his relationship to his analyst. The patient's other criticism was also accurate, namely that the analyst elicited feelings of revenge in him without at the same time also being able to produce the original object of his hate. The image he used of a "horny" man who had neither a woman nor hands to satisfy himself was extremely succinct.

Liberation and Increased Freedom in Acting Toward One's Self

One aspect of liberation consists in the just mentioned *creative use of language* , in images that are condensed representations of feelings.

Conspicuous in the previous sessions was the patient's attitude that he was a victim. He felt persecuted, attacked, and at the mercy of a cruel God who might even demand that he kill his own children. The last session was dominated, in contrast, by his *rebellion against coercion* , rebellion against the unreasonable demands of the surgeon, his mother, etc. Such rebellion against coercion is one element of the idea of liberation. The patient did not want to submit to either an inner or an external coercion that he considered inappropriate.

Liberation is manifested not only in the rebellion against coercion, but also in the capacity to behave toward one's own condition, as has been described by Tugendhat (1979). The patient's capacity to reflect on the current dialogue situation developed in the breakthrough session. The patient succeeded not only in playfully putting himself in his childhood shoes, but also in reflecting on his role. He did not experience himself as a small child but as an adult who felt what it might have been like for a child to have been maltreated. The playful aspect did not prevent him from taking his biography more seriously than before. The patient's vivid description of every detail of various scenarios precipitated strong feelings in him. He was filled with rage when he measured his own childhood against what childhood should be, but also with powerlessness because he had no alternative but to accept what had been. "What my father did was an act of insensitivity of the first order." He asked himself, "What can I now do with my feelings of revenge since the objects of this revenge are beyond my reach?"

In this session, in contrast to others, the patient was able to intregrate his emotional reaction to the setting of the analytic dialogue into his own comments. This was an example for the concept of reflection liberating from coercion. The patient articulated his understanding of his role in the analytic situation and in the process realized that he had submitted to a stereotypical expectation of a role, the role of the patient, in which he has to mention everything he thought of. He reflected on this now as being a coercion to confess, and asked himself whether he wanted to continue in this role, what he could do with the analyst, and to what extent the analyst was able to satisfy his needs. Asking these questions he abandoned the role of passively doing his duty, overcame the apparently prescribed forms of behavior, and acquired the capacity for distancing himself from his role.

Experiencing Symptoms as an Aid in the Formation of Productive Ideas

Arthur Y subjectively experienced his symptoms as part of a struggle against subjugation to senseless rituals that demanded a threatening and frightening superiority. In this session the patient used this subjective experience to describe his emotional state during his confrontation with his oppressors.

We would like to recall that the analyst had attempted in the "bad" session (see Sect. 10.1) to illuminate the patient's experience of his symptoms by referring to an analogy between how he experienced, on the one hand, his symptoms and, on the other, his life. He equated the patient's relationship to the wood paneling with that to his tormentors. In the good session he utilized the patient's momentary experience of his symptoms to emotionally revive his recollection of situations of suppression.

Dramaturgic Technique, or the Stage Model of Psychoanalytic Treatment

In Vol.1 (Sect. 3.4) we compared the events in psychoanalysis with those on a stage. According to the stage model, analysts and patients play roles and also keep an eye on themselves all the while. In addition to acting complementary to the patient's expectations, the analyst has the functions of a codirector and observer. The point is to test the roles that the patient did not adequately assume.

In the "breakthrough" the analyst cashed in on this program. At the beginning of the session described above, he directed his fantasy at making the patient aware of the bloody scenes in the tonsilectomy he described.

How did the analyst know about the bloody details of the patient's tonsilectomy, the overall impression of which moved the patient to put himself in the situation of a tormented 9-year-old boy? In fact, the analyst was not aware of the specific details, but he was culturally close enough to the patient to be able to imagine what had happened. In the stage model the vital issue is not to reconstruct the patient's actual biography but rather to understand, in this instance, how the patient *imagined* that a 9-year-old boy would have felt if he had been handled in that manner.

Analyst's Commentary. It is a pleasure for me that an unbiased outside scientist arrives at interpretations that are compatible with the stage model and even refers to *dramaturgic technique* . The tonsilectomy reminded me first of a tooth extraction I had had as an adult; so much blood collected in my pharynx that I felt as if "I were up to my throat in water." I intentionally use this metaphor that, as all allegories, covers a whole range of experiences. The metaphoric language of therapy promotes the intensity of experiencing. In this recollection I was still completely in control of myself, and at first did not give any sign to the dentist, who was concerned, because I wanted to push this extreme situation to the utmost. In other situations in childhood, however, I was just as powerless as the patient. No reader will have difficulty putting himself into a situation where there is a more or less frightening polarization into power and powerlessness. The psychoanalytic theory of the genesis of unconscious structures and dispositions facilitates understanding. Unconscious schemata of oneself, for example, find vivid representation in dream language. Explanatory psychoanalytic theory, however, leads us to expect that such representations conceal other self-images which find expression in action potentials, regardless of how split they may be from conscious experiencing. Where there is a victim, there is a perpetrator, just as masochism and sadism belong together. Knowledge of this enables the analyst to offer interpretations reviving repressed or split self elements that elicit associations in the patient. I consider the dialogic enrichment to be essential, although actually moving onto a stage and playing psychodramatic theater would make it difficult to formulate the respective

interpretations. It may lie in my personal limitations - namely that I am often unable to grasp and interpret the meaning of a scene in relationship to unconscious motives and structures until I have had time to reflect on it in detail. I can accept Brecht's stage guidelines [mentioned below], and in this sense the term "dramaturgic technique" is accurate.

To clarify the analyst's approach, we can distinguish three ways of writing history. First, a simple chronicler restricts himself to saying what happened. A second historian may want to comment on historical events from his own perspective and thus pursues the goal of explaining history. The third approach is to imagine how it would have been to have lived during a particular period, which is the attitude that many authors and actors have.

The analyst enables the patient to pursue the last approach toward his own biography. In contrast to the historian, who does this on an experimental basis, and to the actor, whose role ends with the final applause, the patient inescapably suffers from his own life history, which dominates his present by means of the repetition compulsion of his symptoms. Thus viewed historically, the therapeutic situation is decisively characterized by opposite movements. On the one hand, the patient's present situation is a continuation of his past; on the other hand, analysis is supposed to help him revise his past in light of his present, at least inasfar as his past governs his life history (Marten 1983). The analyst does not suggest that the patient be the "little shitter" that he probably used to be and who could probably hardly imagine that he deserved to be treated better. The patient's task is to understand what it is like to be in the role of this tormented boy on the basis of the views he *now* has about how children should be treated.

With regard to his directing, the analyst has much in common with Brecht, who did not want the actor to conceal his own view of the character he was playing. If the actor plays a king, then he should not give himself and the audience the illusion that he is the king, but should rather play the role without ceasing to refer to it.

The advantage of dramaturgic technique consists in the fact that it promotes the application of the values to one's self that one has when judging others who are in similar situations. The indignation that was aroused in the patient was made possible by the fact that he had abandoned his previous attitude toward himself in favor of the one he quite naturally had toward his own children. This enabled him to view himself as a child who had been mishandled and cheated of his adolescence, just as he would see his children under similar circumstances.

This change in perspective cannot be achieved solely by means of dramaturgic technique, at the most for a brief moment. How should someone whose obsessive thoughts of murdering his own children play a tormenting role in his symptoms become indignant about a surgeon? How can he rebel against his childhood tormentors, even in his fantasy, given his broken self-esteem? It is thus necessary to supplement dramaturgic technique with interpretations that strengthen the patient's self-esteem. The analyst did this in this case by soothing the patient by giving him the intepretation that his thoughts of murder did not refer to his own children but were a sign of his rage at his enemies, both past and present. The corresponding passage in the dialogue was:

A: Yes, and with the scalpel you're the powerful surgeon, SS officer, Hitler, etc., God the Almighty with the knife, and in the small children you yourself are a child; you're a victim.
P: Yes, yes.
A: But you don't mean your children, of course. You mean the immense power, but it's so terrible that nobody can point the scalpel at you, and this has implications for more distant, seemingly harmless things, such as you're not permitted to criticize the therapist, me.

The patient's thoughts about murder had been displaced onto his own children because he had been incapable of risking these thoughts about the omnipotent force over him. This interpretation gave the patient relief, and he attempted to memorize it. It gave him a basis for

confronting his tormentors. This interpretation, according to which he did not have to view himself as an evil person who deserved to be mishandled, consisted in two parts. The first said that the patient established identifications both as victim and as perpetrator. This was the reason that, when he became aware that he felt satisfied, he was overcome by the anxiety that he might destroy his children and, in the process, himself. The reason was that he was his own victim. He was the murderer of his double, similar to Mr. Hyde, who killed Dr. Jekyll. This part of the interpretation was the analyst's guiding thought theoretically, as we show in Sect. 8.2. The other part of the interpretation was used by Arthur Y. According to it, his thoughts of murder were actually directed at his tormentors, not at his children; they were merely displaced onto the latter because of his anxiety about confronting the power that dominated him.

We have three reasons for attributing a curative effect to this interpretation.

1. The patient expressed an awareness that the interpretation was significant for him. He himself considered it relevant. He was not satisfied with merely knowing about it and calling it helpful; he expanded on it and clarified it.
2. There was a thematic connection between this interpretation and the subsequent comments. The subject of the interpretation corresponded to the main subject of the session, namely the struggle against his enemies, the sadistic teacher, surgeon, etc. The substance of the interpretation was that his thoughts about murder were in truth directed at these enemies.
3. There was a substantive connection between the patient's development in the good session and this interpretation. It is plausible that it was impossible for the patient to be indignant about having being mistreated in childhood as long as he assumed he was thinking about murdering his own children. If he were capable of doing the worst thing he could imagine, then he would be so bad that he deserved having been mistreated. His childhood may explain that the potential sexual offender is a victim of circumstances. A precondition for the patient becoming enraged about mistreatment was that he had to value himself sufficiently to become enraged and reject his own experiences of having been mistreated.

Analyst's Commentary. Both theoretical and technical considerations motivated me to make this interpretation. I am convinced that Arthur Y did not mean his children as individuals but as symbols of his own powerlessness and helplessness. Of course, in his experiencing and especially in unconscious processes the concrete individuals cannot be separated from their symbolic meanings. In this sense the patient was also referring to his children and not only to their symbolic meaning. In order to be able eventually to differentiate between symbol and concrete individual, I employed a negation to enable the patient to achieve some distance, even if it only lasted a brief moment.

In his unconscious his children stood for his younger siblings, particularly for his younger brother whose birth had precipitated his humiliating behavior of dirtying his pants. There were numerous indications that his death wishes were directed at his brother and sisters. To return to the source of his aggressions naturally does not eliminate them or his concomitant feelings of guilt, but it does make it possible to understand the strange and sinister symptoms. In technical terms, a brief period of relief creates scope for reflection. Moreover, I assumed that the reason his obsessive thoughts were directed at his children, whom he loved more than anything else, was because this let him erect a nearly absolute barrier against the destructive impulses of hate that had been completely separated from his ego. This hate had accumulated since his childhood, and although it was split off it was precipitated by minor everyday insults. It was the hate of the completely powerlessness victim who was no longer capable of raising the slightest defensive impulse against his oppressor. It was only much later in the patient's life or enclosed in his obsessive symptoms that it was possible for him to reverse the

sadomasochistic relationship. His children represented his own childhood powerlessness, and he could identify with the repesentatives of power and their cruel deeds, such as the children who made fun of him, with his mother and father, with the sadisitc teacher, with Hitler and the SS officers, and with the vengeful God, who considered absolute submission a sign of love and demanded such behavior.

In formal terms, the question that disturbed the patient was, "Do I think about murdering my own children?" This question has two connotations: first, are his obsessive thoughts directed at his children? and second, does he desire to kill his children? The first question must be answered affirmatively. The patient's obsessive thoughts and his verbal statements are related to his children. This is in fact what disturbed the patient. The second question was, however, even more disturbing to the patient. This is the question the analyst negated. His obsessive thoughts were not to be viewed as signs of a desire to murder his own children. The patient was not mistaken with regard to the persons who were the object of his statements, but he was mistaken with regard to the object of his desires.

Truth of the Interpretation

Were Arthur Y's desires to kill directed at his enemies and not at his beloved children? Did he displace these thoughts onto his own children because of his anxiety about his enemies' awesome power? The question of truth in the following is not related to the analyst's commentary but to the logical understanding of this interpretation, which the patient shared; namely he did not want to kill his children.

An interpretation appears more truthful if it, first, succeeds in putting a large number of motivationally apparently incomprehensible statements into a systematic and comprehensible connection (crieteria of coherence and rationality), second, is compatible with a causal hypothesis that has been well confirmed (genetic criterion), and third, is compatible with the best confirmed hypotheses of psychoanalytic theory. Applying these criteria in this case, there are many indications that at least one component in the formation of the patient's symptoms had to be sought in the fact that he wanted to protect himself against his murderous self-image. It could have been that he thought he was so bad that he had to fear he might kill the children he loved so dearly. The assumption is also justified that in his thoughts he confused the recollection of his siblings and the image of his own children. Yet transference of a certain relationship to other objects does not mean that verbal statements do not apply to the transference objects as well. In this case the analyst's interpretation did not make the patient aware of the fact that he equated his own children with his siblings. The important thought for the patient was that his aggression was actually directed at an external force.

Psychoanalytic Theory of Symptoms

Assumption 1. Symptoms are displaced and distorted gratifications of disapproved and repressed desires.

Assumption 2. People attempt with the aid of symptoms to cope with a traumatic situation.

Assumption 3. People unconsciously attempt to falsify their unconscious and pathogenic attitudes by means of their symptoms; this point can be subsumed under assumption 2. People attempt to cope with difficult situations by trying to falsify unconscious interpretations of situations.

The first assumption agrees with the analyst's commentary; in his unconscious fantasy the patient identified himself pleasurably with his tormentors, accepting their attitude. Assumptions 2 and 3 agree with the following explanation of the patient's symptoms: The patient wanted to hide the fact from himself that he considered himself so evil that he thought he could kill his own children. By resisting his obsessive thoughts about murder, he attempted to prove to himself and others that he was not this bad.

There are contexts in which the different psychoanalytic models of symptom explanation complement each other, and others in which they contradict one another. In this case they are complementary because "identification with the aggressor" can be interpreted both as an attempt to cope with a difficult situation and as an indirect gratification of destructive desires. The hypothesis here is that the defense mechanism of identification with the aggressor evoked a situation that was intolerable for the patient, which he attempted to cope with through the formation of his symptoms.

Symptoms have the function of concealing a negative self-image. This patient's thoughts about murder appear to be obsessive, pathologic, and isolated from his self-image (i. e., he defined himself as someone to whom these thoughts of murder were completely foreign).

Criterion of Coherence. Even the smallest of reasons made the patient feel guilty, as if he had been caught at something. For example, he was hard working and successful, but he regularly experienced panic when his boss called. The great majority of the stories in this 10-hour segment of his analysis were about the fact that he felt anxiety about being ruined or was spontaneously afraid of being responsible for something that was obviously not his doing, such as an accident at which he were merely a witness. He did not tire of demonstrating to the analyst and to himself that he reacted to minor events with unnecessary anxiety or guilt feelings. This might have had the function of showing that in reality everthing was fine except for his obviously irrational reactions, not to mention how he experienced his symptoms.

Another indication for the thesis of disturbed self-esteem was his attitude of being the victim, which the patient adhered to until the breakthrough. Although he was able to recall the never-ending disputes of his adolescence, he did so anxiously, not with anger. If a person assumes he is very bad, then he deserves to be treated accordingly; at the very least, such a person does not naturally assume he has a right to be treated decently. That, however, is a precondition for such mistreatment to elicit rage.

Genetic Criterion. There are also many genetic signs favoring the hypothesis about the patient's negative self-esteem. There is hardly any controversy that role acceptance is an important learning mechanism in socialization. It is plausible that the patient acted toward himself the same way others did, i. e., he internalized the negative attributions of others, which he encountered at every step.

In short, there were many indications that the purpose of his symptoms was to protect him from the conviction that he had murderous intentions and to prove that he was not as bad as he thought. This defense created a negative self-image. Unconsciously, the patient understood himself as being as bad as he had experienced his tormentors to have been toward him. He was even worse than they had been; he thought he was so bad that he could kill his own children. The development of his symptoms can be viewed as the patient's attempt to conceal this murderous self-understanding from himself and to refute it. He experienced his obsessive thoughts as if they had nothing to do with his own desires or self-images, and the successful resistance of the obsessive commands to kill as proof that the suspected impulses to kill were without substance.

If these hypotheses about his symptom formation were correct, then it would have to be grasped as the consequence and means of defense at a second level: The patient warded off the negative self-understanding formed as a result of his defenses. If only the immediate causes of the symptom formation are taken into consideration, then the interpretation would be false: The cause of the obsessive thoughts about murder would then not have been his displaced anger but the defense of his negative self-understanding. His understanding was negative, of course, because of the feelings of guilt associated with his anger.

Insight and Therapeutic Success

Just as the analyst suggested, identification with the aggressor was the defense mechanism that kept the patient from experiencing his anger in connection with his oppressors. Should we therefore conclude that the interpretation gave the patient false ideas?

Our discussion of dramaturgic technique leads us to draw different conclusions. We doubt that the goal of interpretations consists in making a patient *completely* aware of the causes of his symptoms. The goal is rather to concentrate on the cause that may make a curative change possible. The analyst must, in collaboration with the patient, provide him insights into his situation in life. Symptoms are defense products, i. e., inadequate attempts to cope with traumatic situations. In the case of Arthur Y, the patient's experience with his symptoms represents his cumulative experience of suppression and powerlessness in his life. Dramaturgic technique was used to put this experience back into the context of its origin, to give the patient the opportunity to finally confront the situations of suppression and unjust treatment in a positive, self-determined manner, instead of with defense. (On the question of self-determination and volition see Löw-Beer 1988.)

For this prupose it would not have been conducive to make the patient aware of a self-understanding that itself was a product of his defense, only providing a distorted image of his own situation. In his desires to kill his children he identified with the aggressors. He never had the self-confidence to develop anger and to resist the terrible force. The task of analysis was to enable the patient to face the situations of successive traumatic experiences in a nondefensive manner. The interpretation discussed above must be seen as a means for the patient to gain insight into his own situation. Such insight into his situation was a part of a curative change. The concept of curative change has been discussed in connection with acquiring insights, a sign that there is a conceptual connection and not merely an empirical one between therapeutic success and gaining insight into one's situation. Still to be determined is how successful sessions in therapy are related to living successfully outside therapy.

Acquiring insight into one's own situation means both a view of one's own situation that has been freed of defensive distortions and, in particular, an evaluative and emotional change. Arthur Y became mad at his oppressor in the breakthrough, and his anger was appropriate to the torment he had experienced. An evaluative change takes place only to a small degree, if at all, on the basis of a process of achieving awareness. It is also not based on an attempt to reconstruct real experiencing. One element of a patient's altered understanding of a situation consists in the inclusion of the values of the adult patient. This can be shown, for example, in Arthur Y's attitudes about childhood and adolescence. One thing he presumably suffered from was that his mother had shared her concerns with him. As a child he had probably not been aware of the fact that his mother had thus saddled him with the responsible role of an adviser, making him miss something of his adolescence, which he complained about in analysis. Presumably he did not know at that time that juveniles deserve a different role. Another example in this case was that although the history of his symptoms indicated that he had the impulse to kill his sadistic teacher, it was only as an adult that he understood the meaning of sadism and was able to judge how incorrect the teacher's behavior had been. It is an interesting question for further research to determine how much these evaluative concepts are acquired in analysis and whether they take the form of learning processes.

In a certain sense it is necessary to reconstruct the past on the basis of present values. It is, after all, impossible for individuals to voluntarily abstract from all their interests and evaluative concepts. But even here there are some differences in degree. The attempt can be made either to largely abstract from the contemporary perspective and to imagine what a person was like in the past, or to imagine how one would have reacted in a past situation on the basis of current views. The dramaturgic technique enacts the scenic presentation of conflicts from justified evaluative points of view.

10.3 Religiosity

Our Western civilization has been molded by ideas that are a mixture of Judeo-Christian religion with Greek philosophy and the classical Roman view of the world. Its ideas and expressions influence any individual's manner of feeling and thinking whether his education was religious in nature or not. Our language and our system of values are products of this cultural tradition. Every individual lives in a psychosocial reality whose subjective and objective components are mediated by society. A system of values, such as embodied by a religion, constitutes part of both the general and the individual comprehensions of reality because reality must be interpreted and always has been. Even the value system of atheists is largely the product of the ideas incorporated in the Ten Commandments. In our civilization, churches, as represented by their officials, mediate the contents of Christian religion. The traditional images of God have, however, always been influenced by individuals, depending on their personal experiences. People undergo change, just as does religion itself its image of man and God.

The critiques of religion that Feuerbach, Marx, Nietzsche, and Freud pioneered in the previous century embody a projection theory according to which man is the creator of all of his images of God. In the tradition of the Enlightenment, this critique aimed to abolish religion and to substitute atheistic ideas and ideologies for religious systems of interpretation and meaning, both for individuals and for society at large. Even nihilistic systems of thought are interpretations of reality.

The function of such systems of interpretation and meaning - that is, the function of religion, mythology, and ideology for the life of groups, societies, and peoples and for the individuals in them - can be examined in psychoanalytic terms. This is also true of the image of God that an individual has, both as it was given to him and as he has transformed it. It is not difficult to demonstrate that religious ideas fulfill various psychic functions. Pfister (1944), in his book *Die Angst und das Christentum* (Anxiety and Christianity), did this for the Christian religion, showing how one particular one-sided image of God, namely that of a vengeful God, promotes the development of neurotic anxieties. Previously, after Freud (1927c) had radically settled with every religion in *The Future of an Illusion* , Pfister (1928) had responded by reversing Freud's title - the illusion of a future - and accused Freud of succumbing to an ideology, namely that of science. For Freud, of course, this was an honor; his entire work was concerned with scientific enlightenment, which can only strive for preliminary truths. Has Pfister, a theologian, had the last word against Freud because new mythologies and ideologies have arisen since beliefs have been demythologized? Actually, Freud thought that man's capacity to soberly acknowledge realities was so limited that he gave wide room to religious consolations, especially to the belief in a life after death. In contrast to Nietzsche, in whose late works the phrase "God is dead" formed a central thesis, Freud was guided by the human longing for belief that provided support and consolation. According to his well-known description of the relationship between psychoanalysis and religion,

> If the application of the psycho-analytic method makes it possible to find a new argument against the truths of religion, *tant pis* for religion; but defenders of religion will by the same right make use of psycho-analysis in order to give full value to the affective significance of religious doctrines. (Freud 1927c, p. 37)

It has proved proper for analysts to stick to their own skills with regard to all problems of religion, and to use their method to examine the entire extent of the affective significance of religious ideas and the function of belief in the life of the individual within the different religious communities. In the process analysts often see the significance of *projection* for the creation of images of God. It was precisely this discovery of the projection of human fantasies of omnipotence in magical, mythical, and religious thought and experiencing that Freud, following Feuerbach, made the focus of his criticism of religion. Since we discuss these problems in the following case study in the section entitled "The Image of God as Projection," some introductory comments are appropriate.

The concept of projection and its grounding go back to Feuerbach in the nineteenth century. Schneider (1972), who is both a theologian and psychoanalyst, has described

Feuerbach's theory of religion and critically examined the reaction of theology to it. Feuerbach provided a "critical, genetic" explanation of religion:

> Religion is man's earliest and also indirect form of self-knowledge. Hence, religion everywhere precedes philosophy, as in the history of the race, so also in that of the individual. Man first of all sees his nature as if *out* of himself, before he finds it in himself. His own nature is in the first instance contemplated by him as that of another being. Religion is the childlike condition of humanity; but the child sees his nature - man - out of himself; in childhood a man is an object to himself, under the form of another man. Hence the historical progress of religion consists in this: that what by an earlier religion was regarded as objective, is now recognised as subjective; that is, what was formerly contemplated and worshipped as God is now perceived to be something *Shuman* . . . every advance in religion is therefore a deeper self-knowledge. (Feuerbach 1957, p. 13)

According to Schneider, Feuerbach traced religious ideas back to anthropologic phenomena that man was originally not able to recognize as being his own but projected onto his environment. Feuerbach conceived of religion, as Freud did later, as "the infantile nature of man," explaining it with the reference that a child perceives its essence in its parents. He therefore attempted to explain, for example, "the secret of prayer" with the fact that a child "finds in its father the feeling of its strength . . . and the certainity that its desires will be satisfied," concluding that "The omnipotence that man turns to in prayer is . . . in truth nothing other than the omnipotnece of the heart, feeling, which breaks through all the barriers of reason and overcomes all the borders of nature." In summary, he wrote that "The origin, true place, and significance of religion exist only in man's period of infancy . . . " (quoted according to Schneider 1972, p. 252).

Feuerbach sought the true essence of religion in anthropology. The larger part of his *The Essence of Christianity* is entitled "The True or Anthropological Essence of Religion." Freud extended this anthropological turn in the critique of religion by tracing religious and mythical ideas back to the infantile phase of life in an even more rigorous manner than Feuerbach had. The psychoanalytic critique of religion added important new dimensions - even according to Grünbaum (1987b), who referred to the example of belief in Immaculate Conception - by recognizing that taboos that develop during a person's life history are both the source of certain items of dogma and the basis for their plausibility. In this reduction Freud, of course, encountered a myth - that of Oedipus. His study of the origin of man's images of God and his discovery of projection thus led to his criticism of *revealed* Christian truth and, in a comprehensive sense, to demythologization, but also to a remythologization.

Psychoanalysis has contributed to this development in intellectual history in numerous ways, and here we will limit ourselves to mentioning just a few of these points. Freud outlined a *theory* of the genesis and function of myths, religions, and ideologies and created a method of investigation. As a representative of the enlightenment he conceived a reality principle that comprehended the world of facts and whose acknowledgment is a dictate of pure and practical reason. For Freud, science's view of the world leads to knowledge of the connections between facts and thus to truth, which in turn enables one to cope with life in a realistic manner. Facts are contrasted to imagination, and truth to illusion; the world of mythology and faith is molded by fiction and fantasy. This contrast between logic and myth can be traced back to early Greek philosophy (see Dupré 1973).

Proceeding from the reality principle, the process of mythology is primarily considered under the aspect of defense. Long ago Jones (1919) emphasized with regard to the prototype of defense (repression) that the related psychoanalytic theory of symbols employed a restricted concept of symbol. Psychoanalytic theory does not adequately recognize the overall significance of symbolic forms for human thought and action. Langer's (1942) critique of the psychoanalytic concept of symbol, in the spirit of Cassirer, has been discussed in the psychoanalytic literature, which has had a positive effect on the discussion at the theoretical level (Philipps 1962; Lorenzer 1970). The inclusion of the psychoanalytic concept of symbol in a philosophy of symbolic forms represents an extension of the psychoanalytic understanding of religious experience (see Braun et al. 1988).

Explaining elements of religion with reference to the infantile roots of emotional life has its strengths and weaknesses, as does every one-sided explanation. It is by no means necessary for religious feelings to simply disappear in the course of liberation from frightening infantile

fantasies about God. It is also possible in the course of an analysis for new aspects of faith to arise parallel to the modification of those images of God that are filled with anxiety. A psychoanalyst is not competent to judge the *truth* of systems of faith. He can, however, proceeding from Freud's anthropological perspective, have an opinion about which items of faith are appropriate for an individual, i. e., harmonize with his essence, and which contradict it and are antagonistic to his life. Today all religions and world views have to accept the fact that they can be compared with regard to what they contribute to an individual leading a fulfilled life and to achieving a reconciliation between groups and peoples. Directly or indirectly, the psychoanalyst's critical attitude toward culture and religion influences the world view of his patients. Thus to the extent that values are a topic of discussion in treatment, psychoanalysis itself must be willing to accept the same kind of critical examination as has been directed at religion and secular expressions of faith since the anthropological turn. Such an examination cannot bracket out the way psychoanalysts act in their professional work and within the professional community, or the extent to which humane values such as those Freud adhered to are expressed.

In the following example the analyst did not shy away from tracing a patient's image of God back to projections. Although in doing so he was moving on "theological thin ice," he was only temporarily in danger of losing control. He stuck to the idea of negative theology, which he understood as saying that all human statements about God cannot, by definition, reveal his real essence, and that on the other hand it is also impossible not to make "any graven image, or any likeness" (Exodus, 20,4). This attitude is characterized by extreme openness toward all religious feelings. Whether an atheist is willing to discuss his repressed longing for his father, or a member of a sect is willing to examine the function of his belief in the beyond in connection with a presumed approaching demise of the world are technical questions that we cannot discuss here in detail. Decisive is that this openness exists, which makes it possible in principle for an analyst to treat members of all denominations.

Religious questions are encountered in every analysis at least in connection with the issue of guilt. It is often possible to restrict oneself to the genesis of *feelings of guilt* in connection with formation of the superego. Depressive patients, in particular, feel guilty without having done anything to warrant serious and real guilt. Confession and absolution do not reach where unconscious feelings of guilt have entered into a close connection with repressed intentions. It was with this category of patients that the role of the internalization of punishing parents and of the images of God copied from them was discovered. Theology and psychoanalysis meet at the transition from feelings of guilt to real guilt (Buber 1958).

Religious ideas are encountered especially frequently in compulsion neuroses. The psychopathological forms of compulsive defense rituals are related in numerous ways to superstition and magical thought. Anxieties and feelings of guilt, as well as the temporary alleviation provided by typical obsessive thoughts and compulsive acts characterize a syndrome that results in endless repetition of the same thought processes and sequences of events; in very severe cases normal behavor is hardly possible. Both the contents and the forms of compulsive neuroses lead one to compare the function of rituals in the individual's psychic life with those in systems of faith. From a psychoanalytic perspective the issue is to determine the influence that Christian faith and biblical stories exert on the neurotic anxieties of patients. Religious problems arise in psychoanalytic treatment primarily in individuals who have been injured by religion and its representatives, as the following example of Arthur Y demonstrates. The modification of symptoms is thus always accompanied by modifications of the images of God. An unanswered question concerns which religious feelings remain after infantile and magical thoughts lose their influence on thinking and emotions; there are differences of opinions on this issue between individual theologians and psychoanalysts (see Gay 1987; Küng 1987; Meissner 1984; Quervain 1978; Wangh 1989).

10.3.1 The Image of God as Projection

The excerpts of the case history of Arthur Y presented in Sects. 6.4 and 8.2 demonstrate that religious contents and motives played a dominant role in his compulsive symptoms. And apart from his compulsive symptoms, Arthur Y frequently confronted his analyst with religious questions about God's justness and the compatibility of the different images of God. The story of Abraham and Isaac became the sinister and incomprehensible example of sacrifice in which the patient was unable to discover any love. The following example stems from a late phase of Arthur Y's analysis, after he had already acquired a greater inner freedom. Because of the great significance of the problems discussed here, Sect. 10.3.2 contains a theologist's comments, entitled "The Analyst on Theological Thin Ice?" The title refers to a statement the patient made accusing *priests* of avoiding some topics to keep off thin ice.

The analyst's comments about his countertransference were clear indications of his insecurity regarding the problem of potential blasphemy. The "considerations" and "commentaries" were not added to this excerpt until after completion of the theologist's comments, which thus refers only to the uncommented excerpt of the session.

Arthur Y emphasized that he still had not come to terms with his own feelings of claiming power and force. For days he would feel excellent, and his condition would be incomparably better than it had been, but he wondered whether it might just be a forgetting (of anxiety). He had occasional relapses lasting seconds, minutes, or hours. He acknowledged that there had been great changes in the context of his anxiety; he had acquired a more secure basis for enjoying the pleasures of life, and he was able to be generous, not immediately imagining that economic ruin was approaching. He added, however, that his anxiety was still latently present.

Two major topics were still a source of distress for Arthur Y, namely force and sexuality. He came to speak of the Christian religion, asking how the daily struggle to take something away from others or even to ruin them materially could be reconciled with Christian ideals. A colleague had recently looked at him astonished as he had raised this question, and answered, "You can use your God-given abilities, and if they make you successful, then it can't be un-Christian." He had to admit that his colleague was right, adding that Christian forgiveness could not apply to everything. He said the idea of an existence free of force was not realistic and that pushing to get ahead could be observed everywhere in nature - every plant grew towards light and whoever did not keep up wasted away. His religious problems bothered him. He said it had been difficult for him to go to Communion at Christmas.

P: A few years ago I had the thought that if I didn't think of my anxieties when I took the host, then everything would be alright. After I had eaten the host the thought shot through my mind, "Murderer, chop his head off." I was thinking of myself. Then I managed to get my mind on something else and not to think about it any more. The same thing happened to me a few days ago; everything was calm and peaceful and suddenly I thought about the scene at the Communion.

The topic of religion continued to be at the focus of the patient's thoughts:

P: Christmas is the day of celebrating harmony, but just a few days later is Stephan's day, a gruesome history, the stoning of the holy Stephan, who was chased out of town. God even sent his Son to the Crucifixion to achieve reconciliation. My atheistic upbringing created the feeling in me that the world is cold and merciless, but the real world did not agree at all with my natural disposition. And after the Nazis were gone and mother sent me to church for opportunist reasons, I was surprised to encounter a world in which you are accepted and can even have anxiety. The old priest had understood how to

guide me, but the pleasant experience wasn't continued at the parochial boarding school, where I ran into a terrible representative of God.

At the boarding school he had encountered two such representatives, one a repulsively ugly, homosexual seducer, the other a brutal sadist. He thought of Schiller's verse, "Shuddering, it crawled toward me, the monster crawled toward me - that's the impression the repulsive man gave me. This is how I developed the image of a diabolical God." He would have liked to recite several more verses from Schiller's *The Diver* , but did not in order not to create the impression that he wanted to show off how much he knew.

I pointed out to the patient that he referred to himself self-critically as some who boasted, when he wanted to say a few more verses, but interrupted this train of thought to avoid being one. I added that if he continued his story, he would come to the subject of power, and not only the power that affects him from outside, the representatives of his brutal image of God, but also to his own desire for power, which he then can use to assert himself against the strong force.

The patient then took the risk of approaching the monster that was in hiding by saying, "You can only face such monsters if you yourself have power, and then you're as powerful as people in power, murderers, such as God the Father who did not prevent his Son from dying on the cross."

Consideration. In a quiet moment the problem of theodicy immediately crossed my mind, specifically the defense of God against the criticism of also being, as creator of the world, responsible for all evil. Who is responsible for the evil in the world? And what about human freedom. Later I read about several suggestions as to philosophical and theological solutions to the theodicy problem. Yet at this moment I was overcome by a powerful countertransference, having to think of my own education. I sensed that the positive unconscious fantasy was behind the negative formulation that God "did not prevent his Son from dying on the cross." He had let him be killed, which means that in His omnipotence He Himself was the murderer. Overcoming strong inner resistance, I struggled against the accusation that I would commit blasphemy and thought, in my opinion also for the patient, his and my thoughts through to their logical conclusion, saying, "If you think these thoughts through to their logical conclusion, the God the Father killed His own son."

The patient was shocked and relieved at the same time that I had clearly spoken his thoughts.

P: You should say that to a priest some time. He would hit you over the head with his cross.

A: Thoughts of revenge come when you've been tormented. You didn't want to be like that, no vengeful God, no avenging God, and yet you do want to be like that, too. The priest would hit *me* on the head with his cross, as you said. Christ's sacrificial death is supposed to atone for and erase man's guilt.

P: Yes, that's hard to rhyme.

A: The son submits. Let not my will, but let thy will be done.

P: It's just natural to ask how something like this can fascinate and subjugate so many people for more than 2000 years. Anxiety and fascination. If the host had fallen on the floor, it would have been a catastrophe. Yes, it's impossible to touch the Lord God with your fingers. I would never have had the nerve to so in such a blunt way that God killed His own son. If I were to think such a thing, I would be punished. Then I would have to kill my own children. I've needed all this time to think these thoughts through to their logical conclusion.

A: Yes, if you had put my words into your own mouth, that is if you expressed your criticism yourself, if you became indignant about the subjugation you've

experienced, if you rebelled against those in power, then you would be butchered like a sow [an allusion to a masochistic thought of the patient].

P: You told me once that you are protestant and had a Christian upbringing. How do you come to terms with saying that God is a murderer if you are Christian? How does that go together?

After reflecting for a long time, I gave an evasive answer: "What does Christian theology say about it?" I referred to the general theological statement that sacrificial death is the symbol of God's love. The patient was very relieved at having managed to talk about these thoughts that had repeatedly tormented him for a long time.

P: Should I be happy that I have talked about these ideas, or should I feel anxiety? I'm not satisfied with what you said.

A: Yes, you can't be satisfied with it.

Consideration. I could not think of anything else but to confirm that the patient was justified in feeling dissatisfied. I avoided the issue by generalizing it, because at the time I did not know how to proceed. At least I gained some room for making some therapeutically more helpful statements. My confirmation encouraged the patient to let his dissatisfaction motivate him to more intensive reflection. As a result, my evasiveness did not have any lasting negative consequences, as shown by the further course of treatment.

The patient then began to talk about the movies about Don Camillo and Peppone, a fictional priest and communist politician in a small Italian town.

P: Don Camillo talked with God as if they were equals. He carried the cross and talked with God or Christ as if from man to man, calling upward "Hold on tight!" when he wanted to use the cross to hit something. One side of God is similar to the sadistic teacher. The corresponding idea is, "Duck, keep down low, hide in the masses so that you're not conspicuous." It must have been that way in the concentration camps. A person was a little more secure if he didn't raise any attention. But that means crawling like a worm, lying flat on the ground or, even better, underground.

A: So, Don Camillo spoke with God as if they were equals and asked, "Why didn't you keep your son from being killed?" He wouldn't have said, "Why did you kill your son?" That would be an active deed. But the question of why God did not prevent the sacrificial death, this question even keeps theologists busy. According to the Bible, God's power extends over heaven and earth.

P: Yes, these thoughts are convincing, but you have to have the nerve to talk about them. I remember a radio play about a blasphemer who was threatened that he would be struck by lightening. And a little later there was a thunder storm. In the play this man trembled until it was all over, without being struck by lightening.

A: Many people simply don't dare to use their reason and think. Blasphemy is immediately followed by a bolt of lightening. You are punished by the mental bolt given to you by the all-powerful teacher - God in Heaven.

Consideration. My goal in this interpretation was to personify natural events and to create something in common between the different bolts, whether of lightening or of ideas, or to find similarities that could have common roots in the polarity of power and powerlessness. The comment about God as a teacher was an allusion to a sadistic teacher who had thrown bolts that, in turn, had caused a thunderous echo in the patient's compulsive neurotic ideas.

P: Yes, Don Camillo did something wrong. At the Crucifix he asked for God's forgiveness and promised not to smoke his cigar again, which was a great sacrifice. After he extinguished his cigar, the voice of God, from the Crucifix,

said, "Don't just extinguish it, throw it away, don't put it in your pocket." And in fact Camillo had had the idea of smoking his cigar later on in his pipe, and was caught thinking about it - a funny story.

A: Yes, this God could have fun, but the other one, the cruel one, who met you in the person of your sadistic teacher . . . .

In the next session the patient spoke about the liberating effect the last session had had, even though he was shocked at my statements. He became more secure in talking about things that previously had been bracketed out. Yet something sinister remained:

P: The apocalyptic riders could come or, more simply, something could happen like in the boarding school, when a boy was beaten so badly that he later committed suicide. All of this was decisive in my development.

A: It's natural to forget the sinister, which is why everything in the last session seemed so new to you, as if you had never had such ideas before.

P: True, but you hadn't said it as explicitly before either. God, a murderer, the building ought to collapse.

A: You feel better not just because there hasn't been a catastrophe, but because I said the sentence. If God is angry and kills someone, then you won't be the victim, I will. I was the bad guy, the blasphemer.

P: Yes, you said it, but I was the reason, and that made me feel my anxiety. I settled down by telling myself that you said it, not me. It was only afterwards that I also felt proud. At first I was shocked and horrified. No, I was rather proud that I had gone as far as I did, and yet I'm still a little concerned that I brought you to say something blasphemous. I've known you long enough to know that I should take you seriously, and in response to my question about how you come to terms with it, you withdrew to a theological explanation. You didn't tell me your own opinion. To return to Don Camillo and his discussion with God about the Crucifix, Don Camillo asked, "What didn't you keep it from happening?" This question is much weaker. You just can't simply go and say such a blasphemous thing. I'm not the only one who would lose his breath; thousands would react just the same way. I told you the story about the host that I couldn't let fall on the floor.

A: Well, I'm responsible for what I said. And by taking the responsibility, I provided you relief.

P: I've observed myself a little more in the last few days. I noticed that I've sometimes attempted to avoid making visual contact. If I don't look at him or them, then they don't do anything to me. [Long silence] I'm not happy with one of your comments, namely that I don't risk something until you make the first move. As if you were taking something away from me that I thought I could have - a bit of courage. Well, you could see it a different way [the patient laughed]. You could say that I showed the courage to follow you after you had gone first.

A: Or to go in your own tracks.

P: I'd like to go back to the sentence and ask you directly, Don't you feel any anxiety about saying something like that? Didn't you really go a little too far? Did you lose control of yourself? Or is my memory fooling me? I can't imagine that I provoked you to go that far, so your emotions must have got the better of you; that would at least be an explanation for what you said.

A: Would it be eerie if you had so much power and provoked me to blasphemy?

P: Yes. I've just had the thought that I made a suggestion to a colleague, a manager, about how to solve a problem at work and he liked it very much. Why

is it so hard for me to accept the fact that I can also have some good ideas? So, if I had the power to provoke you to make such a statement, I don't believe it would seem as sinister to me now as it would have before.

A: Yes, you did motivate me to make this comment. But I didn't lose control of myself. I'm in the company of many important theologians. It's a fundamental question of Christian theology to ask where evil comes from. Since God created the world, the problem is why he didn't prevent evil, that is, why he let it happen that his son was killed. I left out the intermediate step to make it clearer that an indirect or secondary act is also an deed.

P: I had the subliminal anxiety that it was impossible to speak about it and couldn't have any intellectual models for it. So, it's not only my problem. These contradictions don't only affect me, but thousands upon thousands of other people. Why isn't this issue a topic in church if everyone worries about it. Is it because priests don't want to go out on thin ice?

The patient began to speak about sermons that handle fundamental topics such as hate, love, reconciliation, and sacrifice, issues which had already been expressed in mythologies in the pre-Christian era. He said,

P:I'm amazed that people don't ask more often why they speak about a *dear* God. I might be able to answer this question from my own life history: They beat the desire out of me to ask critical questions.

With these thoughts a session ended that was memorable for both participants. It helped the patient to become able to integrate projected elements of his self.

10.3.2 The Analyst on Theological Thin Ice?

In order to provide a meaningful commentary to this impressive session, which seems to be a very condensed version of a problem affecting mankind, it is advantageous to examine the following five issues:

First, what do we learn in this vignette about the patient, his illness, and his progress in therapy, in connection with his biographical data?

The patient was pursued by his feeling of power and force, which was linked with his anxiety that he might do something to someone close to him. His fantasies of omnipotence, in which his own thoughts were attributed magical power, were turned around, making the patient the powerless victim who was destined, for example, to be ruined economically. He felt as if he belonged to two worlds, one in which he was accepted and could have anxiety, and another that was colored with sadism and sexuality and that he internalized via identification. Although he was "terrified about the envy of the Gods," he was now able to see that the scorned drive to have power was in himself. Yet his recognition of his own ambivalence was opposed by resistance that strove to achieve a clear distinction between the spheres of good and evil. In symbolic communication the analyst went first, taking the patient's place and saying the blasphemous thought about God's ambivalence. With this protection the patient was then able to approach his own ambivalence, which however cannot be logically connected.

By breaking the taboos, the analyst enabled the patient to discover "legitimate" possibilities for developing his own power in his life.

Second, what role did the patient's religious fantasies play in his treatment, especially against the background of his religious socialization? Did they facilitate his treatment, or were they used by his resistance? Which interpretative aids did he use himself, and which were provided by psychoanalytic theory?

Arthur Y apparently had the option of being able to express himself in myths. When he did, there was no difference between the outer world and his inner world, the ideal and the material coincided, subject and object were not separate. He felt as if he were the battleground of numinous powers that had to be kept separate at all cost. Everything was alright if he did not

have to think about evil while he was being given the host during Communion, when his ambivalence was gone. Yet he still felt that this was no solution, and he sought for oppotunities for expressing his ambivalence. In passing he managed to say, "God, who accepted the Crucifixion of His Son for the sake of reconciliation." His image of the "diabolical God," the God who kills, reflected the dark side of his desire for power and force. He referred to the figure of Don Camillo as an aid in interpreting the dilemma of a God who is omnipotent yet also suffers; the irony is that he described a God who has humor and accepts the ambivalent qualities of his earthly representative, just as the patient was able to accept the fact that his analyst temporarily had the function of a substitute and to find new opportunites to use his own power.

The manifestation of mythical structures in relatively many situations in psychoanalysis is good reason to consider one of the fundamental problems of psychoanalytic theory, namely its "scientific" self-understanding in contrast to the "mythical" mental structures of many patients. Psychoanalysis, as a science in which "explanation" and "understanding" are linked in a unique way (Thomä and Kächele 1973; Körner 1985, pp. 51 ff.), has itself contributed to a substantial revision of the intellectual climate, resulting especially in a new evaluation of the problem of myth in science. The hope that all mythology would be completely resolved by depth psychology, being traced back to the projection of unconscious desires and fantasies, has turned out to be an "illusion" (Pfister 1928).

Some philosophers today assert that "there is absolutely no theoretically necessary reason in science or philosophy" to reject myths (Hübner 1985, p. 343). "The myths that teach us very simply what constitutes a value are inevitable if human civilization is to exist" (Kolakowski 1974, p. 40). In contrast, the uncontrolled return of repressed myths, which has almost the strength of an eruption, is diagnosed as a weakness of our civilization (Hübner 1985, pp. 15 f.). A mythical element is hidden in numerous manifestations of our civilization (Hübner 1985, pp. 293 ff.). Furthermore, the chance has been described that conscious examination of mythical material can provide insight into repressed desires (Heinrich 1986, p. 240). There are many indications that remythologization is now taking the place of demythologization (Schlesier 1981; Vogt 1986). Following this small philosophical aside, we now turn back to the intervention strategy in this case.

Third, what did we experience about the analyst in his relationship to the patient and his religious ideas?

Initially the analyst apparently felt he was the advocate of "reality." He did not shy from taking a realitic standpoint. He attempted to use the idea of "nature" to mediate between the pompous and utopian ideals and conditions as they really exist. He probably feared that the two poles in the patient's ambivalence might break apart. He raised the latter to a new level by referring to the patient's mental wizardry, while at the same time drawing attention to the patient's own critical impulses toward it, which took the form of subliminal scorn and mockery. He used the patient's religious fantasy (the Crucifix as a weapon) to lead him to his own sadistic fantasies. He attempted to confront him with the scene of his "submission," to show him that rebellion is also punished by terrible penalties. He formulated for the patient the blasmphemous thought of an ambivalent God, but retreated to a general theological stance when the patient insistently asked how this could be made to agree; the patient was naturally not satisfied with such a response. He again approached the patient's ambivalence with the aid of a two-God theory (the God of Don Camillo and the God of the sadistic seducer), showing the patient his own hidden power, which he had used to provoke the analyst into making a blasmphemous statement. The frightening and isolating aspects of his ambivalence entered, on the one hand, in his identification with the analyst, and on the other in the general problem of mankind that could not be resolved by logic and for which there were no clearcut answers.

The analyst thus found himself in a dilemma of either putting himself and his own religious or nonreligious attitudes in the forefront, as an object of identification, or leaving the patient too alone by referring to the general problem of mankind or a "theological topography" that stayed at a very general level and for which the analyst had no responsibility.

What can help the analyst orient himself in such a dilemma, which has been neglected by both psychoanalytic theory and technique? It is a mistake to believe that mythical-religious

images that are antagonistic to life will disintegrate of their own. Is the analyst left with the role of a nonparticipating observer who has to wait to see what develops on its own? This would certainly be a fateful misinterpretation of the inner dynamics of the therapeutic process. The analyst must also attempt to become aware of his own attitude toward the subject of religion in order to be able to handle his countertransference in the best interest of the patient. This is true even if he attempts to avoid as long as possible making a premature decision when a value conflict arises between him and the patient. I therefore ask:

Fourth, how is the subject of religion present in the analytic situation and in the interplay of transference and countertransference?

The structure of the scene described above is very strongly molded by the character of the substitute function and was interpreted by the analyst as such. As an auxiliary ego, he took the patient's place in stating the idea that the patient was still unable to verbalize. It contained the traits of the religious material provided by the patient. Yet to me it seems characteristic that here the transference was not molded by the image of his father (about whom nothing is said in this scene), but by that of the son who, although obedient (even he frequently withdrew to authority), also violated the taboo of his definite father with his blasphemous thoughts about ambivalence, which symbolized rebellion and indignation. To me, even the analyst's countertransference seems to be characterized by ambivalence. On the one hand, he saw himself as the representative of reality, while on the other he became so involved in the patient's religious fantasies that he attributed them a supraindiviudal realistic substance, which enabled the patient to feel linked with both the analyst and all of mankind. That the flash of a thought was not followed by one of punishment helped the patient to loosen the defense mechanisms of denial, isolation, and undoing and to experience his ambivalence.

This scene from therapy thus demonstrates clearly the ambivalence in religious fantasies. The fantasies were impressive reflections of the state of the analytic process. If a patient refers to religious ideas in treatment, then it is advantageous if the analyst has achieved a certain degree of awareness as to his own position toward these problems. He should have a clear understanding of the role that mythical and religious fantasies play in how a civilization understands itself and in its attitude toward its own intellectual history. Although the "enlightenment" hopes of the early psychoanalysts have not been fulfilled, this does not justify uncritically portraying myths as archtypical phenomena that are "ubiquitous, transhistorical, latently present, eternally returning [and that constitute] an inner bond between humans of all times and places" (Drewerman 1984, p. 165). Our insight into the historical transformations of myths prohibits such an understanding, just as some of Drewermann's other views are dubious for psychodynamic and theological reasons (Görres and Kasper 1988).

By assigning the concept "work" a central role in therapy and in the description of endopsychic events, Freud specified the decisive solution to the problem of the relationship between nature and history. Man's nature acquires its history by means of psychic work, and the psychoanalyst takes active part in these processes at both the individual and collective levels. Regardless of whether he wants to or not, he is inevitably involved in the "work with myths" that is considered to be such an urgent task (Blumenberg 1981, pp. 291 ff.). He should accept this responsibility with a greater awareness and willingness than seems to be the case at the present. This leads to my last question, which was the reason for examining this excerpt from therapy.

Fifth, why do psychoanalysts act so hesitantly toward the issue of religion, as if it were a taboo, and why is the violation of taboos such an important task for psychoanalysis?

Freud initiated the transformation of mythology into the psychology of the unconscious, and he was convinced that "a turning away from religion is bound to occur with the fatal inevitability of a process of growth" (1927c, p. 43).

The ubiquity of religious ideas, which take on more or less drastic forms in many analyses, is a reminder for us to concede these ideas their relative justification. They are after all an excellent means for expressing psychic realities that are very difficult to communicate in everyday language as it has been molded by purposive rationality. Of course, it is then necessary to make the effort of making substantive distinctions! The case discussed here obviously involves two different religious ideas. On the one hand, there was the attempt to

isolate the sacred and the profane, separate good and evil, to treat them as absolutes and play them off against each other. On the other hand, there was the possibility, created by the idea of a substitute, to unite both sides of this ambivalent conflict; although this led to a logical contradictions, it provided the patient emotional relief and liberation.

For the patient's therapeutic progress there seems to be no doubt that the first idea inhibited him while the second apparently promoted his development. This implies a value, yet it is impossible to determine whether it is actually due to the results of psychoanalysis, or whether it has to be considered the result of the evolution of mankind's self-awareness and of religion as one of its means of expression.

The psychological comprehension of religion, which was in full blossom in the early days of psychoanalysis (see Nase and Scharfenberg 1977), has probably come to an impasse because the initial hopes for a complete transition to psychoanalysis were not fulfilled. Yet it did violate the taboo that mythical and religious ideas had to be respected at all times and places as the embodiment of constant and highest values. The unveiling of the ambivalent character of these values opened up the task of working them through, a task which Oskar Pfister - who has been forgotten by both psychoanalysts and theologians although he was a lifelong partner in Freud's struggles - pursued his entire life (see Freud and Pfister 1963). The psychoanalytic critique of religion has since taken on new forms and been further developed (see Scharfenberg 1968; Küng 1979, 1987: Meissner 1984), probably creating an entirely new situation compared to the bitter feuds during the infancy of psychoanalysis. The contribution of psychoanalysis to this new situation is, however, still unsatisfactory. The clinical excerpts that are the object of this commentary demonstrate very clearly that more such collaboration - which has already broken many religious taboos - is urgently needed.